IRPP TASK FORCE ON
HEALTH POLICY

RECOMMENDATIONS TO FIRST MINISTERS

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WHY CANADIAN MEDICARE IS IN NEED OF REFORM

Public Concerns

Canadians are worried about their healthcare system.

Blurring entitlements and shifting costs from government to individuals are key concerns for the Canadian public. As some services move from the hospital to the community and the home, which services should Canadians expect to be fully covered by Medicare? Which coverages are reduced, and which services are no longer insured by our public system? Why are drugs and home care covered in some provinces but not in others? These are all legitimate questions.

Canadians are experiencing both a growing personal burden of assuming the responsibility of caregiver for family members with acute and chronic care needs as well as a growing financial burden for drugs, home care and long-term care.

There are several roots to this erosion of faith. These include:

- A theoretical definition of Medicare that no longer relates to the actual health care that Canadians are receiving and have come to expect;
- Crisis mongering in the media;
- Conflicting visions of what constitutes the optimal approach to meeting the healthcare needs of Canadians among federal and provincial governments as well as between these governments and the public;
- A lack of clear goals in the health system; and,
- A lack of clear lines of accountability between the public and the providers and managers of health care.

These perceptions reflect very real problems that must be addressed. Canadians on waiting lists are not imagining their anxieties. Delays in diagnostic imaging and radiation therapy are real. Many smaller communities lack health resources.

The problems fall into four clusters:

- The absence of *excellence* as the standard sought for the system;
- The respective *goals and modes of accountability* of the federal and provincial governments for the overall planning and organization of the healthcare system;
- The *management of healthcare services delivery* in communities across Canada; and,
- The *stability* of healthcare services with regard to both funding and leadership.

Excellence

After nearly a decade of cost cutting, some Canadians have lowered their sights from an excellent healthcare system to one that merely meets minimum standards. This is unfortunate. Canadians should demand and expect excellence, not mediocrity.

Greater Accountability

The paradox of Canadian Medicare is this: it is, in essence, a federal commitment to uphold basic principles in health services, which are then managed by the provinces/territories and funded by both them and Ottawa. The significant shift in the share of healthcare funding between the federal and provincial/territorial governments in the last decade has resulted in very real differences in perspective between the federal and provincial/territorial governments as to their respective jurisdiction and their entitlement to define healthcare programs.

Meanwhile, the system lacks clear goals and is not sufficiently accountable to the public. While the original principles of the *Canada Health Act* remain valid, they are no longer sufficient to address the new realities and emerging challenges of health services delivery. Nor do principles substitute for strategic and long-term planning to anticipate the growing pressures on healthcare delivery and the changing healthcare needs of Canadians.

A notable example that is generating increasing alarm among healthcare professions across Canada is the future of health human resources, which have been inadequately planned and managed. To be sure, shortages of some health personnel are global. But others are domestic and preventable through better planning of health professional education and better management of health human resources. Rigidities in collective agreements prevent labour force restructuring and re-skilling. Unlike other industries, the failure to resolve these issues remains an obstacle to creating a more effective workforce and better, more satisfying healthcare jobs.

At the provincial level, even with the advent of regional health authorities in most provinces, the decision-making structure in health services remains too centralized/micro-managed. Local healthcare organizations lack the flexibility and incentive to manage well. A paralysis results, with far too many decisions requiring ministerial involvement.

There are also tensions between governmental and public objectives: Governments are trying to eliminate their deficits and citizens/taxpayers want lower levels of taxation, objectives that have driven cost cutting in all government services, including health care.

The Management of Healthcare Services Delivery

Medicare as defined under the *Canada Health Act* includes the services provided by doctors and hospitals. However, the movement from hospital-based care to a greater emphasis on home and community care has eroded insured services. To date, governments have not addressed this issue with respect to either continuity of funding or continuity of service delivery.

Quality health care today requires a complex and interdependent relationship among patients and healthcare professionals and among the various types of health services: hospital care, home care, long-term care, rehabilitation and palliative care. In all of these instances, quality and timely care is dependent on effective interpersonal and inter-organizational communication and shared information systems.

In reality, Canadians do not have consistent access either within or between provinces to this range of healthcare services to meet their needs. Organizational and information barriers among providers of care and financial limits on insured services constrain access to an appropriate range of services.

For example, all provinces cover the drug costs of in-patient care, but few provide comprehensive coverage of the drug costs of out-patients or recipients of home care services. Evidence across Canada would suggest that substantial costs have been transferred to patients as in-patient care has declined as a portion of total care. Likewise, home care coverage is uneven across Canada, placing both financial and home care burdens on patients and their families.

As research discoveries and information technology expand the horizons of knowledge, both for the healthcare practitioner and the public, an issue of increasing concern is the linkage between research and decision making in the health system. Experience suggests that the management of services is shaped more by history and politics than it is by empirical evidence.

Greater Stability

Quality health care in the 21st century requires a significant, continuing investment in the physical plants and equipment that provide direct patient care, and unprecedented investment in diagnostic and information technology to support this care. However, the Canadian healthcare system has lagged dramatically relative to other countries in making these necessary investments. Under-investment is evident in capital plant and technologies, particularly diagnostic imaging; it is also a problem in information technologies and management. The health system is less "wired" than banking and other sectors of the economy.

Medical research is yet another victim of under-investment. This has been addressed partly through the creation of the Canadian Institutes of Health Research (CIHR). However, Canada still trails other nations in health research spending.

Stability is not, however, simply an issue of funding. Health Ministers and their senior officials, Deputy Ministers of Health, represent an essential leadership group within the Canadian healthcare system. Yet, turnover within this group has reduced their average length of service as Ministers and Deputy Ministers to less than two years. Only First Ministers can address this source of instability. Over the past forty years, Canada has been well served by the stability and tenure in the key positions of Minister and Deputy Minister of Finance. It is time for First Ministers to seek the same stability in the two key health posts. Consideration should be given to appointments of Deputy Minister for five year renewal terms. As well, First Ministers should endeavour to keep their Health Ministers in place for five years, barring adverse electoral consequences. A decade of renewal will require stable leadership to review and modernize important partnerships.

The IRPP Task Force on Health Policy has focused on a variety of potential solutions to deal with these complex challenges of excellence, accountability, renewed partnership and sustainability. Our specific ideas are set out in the remaining papers in this series. Before considering those ideas, it is important first to review the current and future rules of the health policy game, and, second, to underline the need for a new vision in health policy for First Ministers and all Canadians.

New Rules for Healthcare Services

For over 15 years, the healthcare debate in Canada has been framed by the five principles of the *Canada Health Act* (1984). More recently, the forces of changing technologies, expanding public expectations and the fiscal crisis of the 1990s have challenged these five principles. Moreover, many Canadians believe the principles of the CHA are no longer fully adhered to in health services delivery.

PRINCIPLES OF THE CANADA HEALTH ACT

Universality
Accessibility
Comprehensiveness
Portability
Public Administration

These principles have served Canadians well but they need to be reinterpreted. Public expectations have changed since 1984. What if we modernized the healthcare system by having the courage to review the old rules? What would the new rules look like?

The old health system in Canada has featured endless, annoying battles between provider groups (doctors, healthcare unions) and provincial governments. As well, the federal-provincial war over funding and the assignment of credit and blame has been loud and long. The roots of these battles are structural in nature. They are built into Medicare's inherent tension between providers and payers and among levels of government. A broader set of principles will not eliminate conflict, but it could lead to a more reasoned debate. In addition, broader principles may enable the system to better meet the concerns of citizens in areas such as timeliness and quality.

The following is our proposed "*Medicare Plus*" set of rules:

Universality — Acknowledged as the number one priority for Canadians in our healthcare system, universality equates eligibility for health services with citizenship. Often termed the "solidarity principle" in European countries, universality in Canada means that all citizens and most residents are covered for necessary health services. The definition of health services has evolved to include medically necessary physician and hospital interventions as well as some coverage for drugs, medical devices and home care services.

Accessibility — Access on the basis of medical need rather than ability to pay remains fundamental to the Canadian approach. Moreover, access is gradually being redefined as "timely access to needed services" in light of the emergence of waiting lists for essential services. What is a reasonable waiting time for a given service? Access is also a dimension of Canada's geography. What services should be made available in what areas? How we deal with the costs of patient travel when services are not readily available is yet another emerging issue.

Comprehensiveness — Medical necessities are no longer restricted to traditional notions of hospital-based care. In a world of increasingly successful drug treatments and alternative modes of delivering health services, we have an opportunity to redefine the "package." With home care coverage and adequate drug coverage, the Canadian health system would have a much more solid claim to comprehensiveness.

Portability — Portability remains a viable principle within our system. However, there needs to be a reinforcement of the reality of coverage that is transportable across Canada. At present, portability is sometimes uneven. Citizens are less than clear on the rules outside their home provinces and some provinces are not reimbursing patients in a timely way. And as Canadians continue to "connect" with the global community, there is reason to consider restoring minimum public coverage for out-of-country travel.

Public Administration — We need public governance and public policy direction and standards for health care, but not necessarily public management. What is the right mix of direct public versus private management? How should public administration be interpreted in the new context? Regional health authorities have been established in nine provinces, and

large multi-site hospital organizations are increasingly common. These health organizations, accountable to the public, are outsourcing many functions to the private sector. In the non-clinical areas of laundry, food services and building maintenance, this process has been controversial largely with bargaining units. But the public remains wary of for-profit sector involvement in clinical areas. For instance, Alberta's Bill 11 generated considerable unease and controversy with the public. While the bill is acknowledged to be fully within the CHA definition of public administration, its passage has opened a debate about the full definition of public versus private health care.

Quality — We need new rules to include the quality of health services as a fundamental and measurable aspect of the delivery of care. We understand quality to include not only how a service is delivered but also its appropriateness to the needs of the patient and the outcome for that patient. Quality needs to be benchmarked to leading international standards.

Accountability — The healthcare system must be transparent and accountable to the public as well as to governments, for resources used and results achieved. The public health component needs to be "ring-fenced" to protect funding and to ensure its accountability.

These new rules of the game respond to public concerns, changing technologies and the realities of health care in the 21st century. A vital Medicare system needs to retain the best of its past and evolve in response to the new requirements Canadians are making of it.

Vision vs. the Lowest Common Denominator: A Choice for First Ministers

An unfortunate reality of Canadian federal-provincial relations in health policy is that good ideas are often lost in the heat of battle. Witness the current debates during which headlines proclaim that "home care is off the table" or a "national drug plan is off the table." Eventually, with enough vetoes by various provinces, only the dollar amount of the Canadian Health and Social Transfer (CHST) is left on the table. While this may satisfy the "deal-at-any-cost" mentality, which often seizes complex negotiation processes, it will not serve Canadians well. Political agendas are capable of greater statesmanship and visionary leadership.

An alternative would be to start with a shared vision. Most governments have issued visions of broad health policies in recent months, visions that are very similar across Canada. All of them feature greater emphasis on prevention and wellness. Each of these statements also foresees the modernization of healthcare services. Translating these broad visions into robust healthcare systems is the task for political leadership. Canadians are very concerned that, without renewal, healthcare services will not be there to meet their needs.

A new agreement to review Medicare, inspired by these statements of vision, will be more difficult to reach, but it will meet future needs much more effectively than a narrow financial deal. Achieving the right agreement will require a longer negotiation process follow-

ing an initial framework agreement. But our governments have had success over the years in multi-stage processes of setting a framework for negotiation first, then taking the time to work out the details. Such a process, transparent to the public, may actually lead to more informed choices and better outcomes.

A key framework commitment and a process for arriving at a fully reformed healthcare system would be a compelling step forward. Health Ministers and senior officials could work on the details and report regularly to First Ministers. In 12 to 18 months, our governments could achieve a long-term national plan for healthcare reform.

A necessary framework for this process would set out the common vision of all governments, including the main areas of renewal and the mandate of those engaged in the process. The details of expanding into new programs may require lengthy negotiations. However, commitment to the principle of expanded coverage would be a good starting point. Commitment to a vision, to certain basic principles and to a timetable for negotiation would indeed be a major first step in the full renewal of Medicare.

Canada can and should excel in health and health services. We have a global reputation for excellence in health care and universal access to care in the health field. But can we rebuild the reality that supports this reputation?

RETURNING LOCAL INITIATIVE TO HEALTH SERVICES

Clarifying Local, Provincial and Federal Roles

Canada is an enormous country, happily diverse and becoming more so. But this diversity comes at a price. In health care as in other public services, "one size fits all" poorly. Yet, equity and solidarity demand adherence to principles derived from common Canadian values and based on shared expectations of service standards. These imperatives can all be met by allocating responsibility and authority according to the principle of subsidiarity, i.e. the level of governance that is both closest to the people and best able to deliver a given service should be responsible for that service.

The *Canada Health Act* requires that health insurance plans be administered by the provinces and territories and carried out on a not-for-profit basis by a public authority. In practice, the provincial/territorial governments have interpreted the principle of "public administration" to mean much more than that. Certainly, partial responsibility for the management of services has been devolved to local or regional authorities in nine of 10 provinces. And in Ontario, the exception to this rule, some devolution in health services management has been achieved through multi-site hospital organizations.

Nonetheless, too many key decisions continue to be made in the provincial departments of health. Healthcare providers and Canadians in general are frustrated by distant anachronistic (micro) management from above, according to extensive and detailed rules and regulations. Central approval is still required for any significant allocation of resources. Purchasing an MRI machine, opening a new clinic or focusing resources toward a community's particular healthcare needs all require the minister's signature — which too often comes late or not at all. The result has undermined the once deep and still essential commitment of local, volunteer decision-makers to find innovative ways of meeting the needs of their community. The authority of local governance and management are also undermined.

To ensure the continued health of Medicare, we must renew our commitment to local initiative and autonomy. We must reallocate to local or regional bodies the responsibility and the corresponding authority for managing and operating the healthcare services needed by the people in their communities.

This goal would be better achieved if all tiers of authority in health services had a clearer understanding of their roles. As an example, these many roles and responsibilities could be disentangled and clarified in the following manner:

Local/Community/Regional Health Organizations (hereafter, health organizations) made up of elected and/or appointed representatives of populations of not less than 100,000 people[1] should:

- Coordinate the operations of all healthcare service providers in a given region to ensure the provision of high-quality care necessary to meet the community's healthcare needs;
- Purchase the services required to meet those needs with funds derived from provincial/territorial governments; and,
- Discharge clinical and fiscal accountability for health outcomes and the status of the population served.

Provincial and territorial governments should:

- Clearly articulate and communicate a vision of what their healthcare systems are to achieve. That vision would permeate all healthcare operations in each province/territory and include establishing qualitative and performance standards and expectations for healthcare services;
- Develop policies to ensure adherence to the overarching national principles (referred to below) and to achieve the provincial/territorial vision of health care;
- Establish and maintain data standards and health information management systems, preferably in co-operation with the federal and other provincial/territorial governments;
- Ensure accountability for the operation of the healthcare system in accordance with legislated policies;
- Oversee health professional education and highly specialized health services that for reasons of quality and economy of scale should be provided in one or very few facilities in a province or territory (or, in some instances, be shared with other provinces or territories);
- Devolve responsibility and authority for the direction, operation and management of all other healthcare services to health organizations that "provide or arrange to provide a coordinated continuum of services to a defined population and

(accept) clinical and fiscal accountab(ility) for the outcomes and the health status of the population served"[2]; and,

- Provide funding to health organizations commensurate with their responsibilities.

The federal government should:

- Together with provincial and territorial governments, develop consensus on and interpret the values of the Canadian people regarding health care, ensure that these values are reflected in the overarching principles that guide legislation and frame the delivery of service, and make certain that they are applied equitably everywhere;
- Provide sufficient funding to the provincial/territorial governments to enable adherence to those principles applicable to healthcare services throughout the country;
- Either directly or through an independent advisory body, ensure that all agents in the delivery of health services strive for excellence — whether in services, research or the health industry;
- Take responsibility for and fund directly health and healthcare services within its own jurisdiction, such as fostering health research and its application, providing health services to Aboriginal populations and regulating drug safety/efficacy; and,
- Accept responsibility for and fund such healthcare programs as the federal, provincial and territorial governments may jointly agree are best offered on a country-wide basis.

This clarification of responsibility and authority for health services does not represent a hierarchy of roles. Rather, we seek to differentiate and disentangle roles, to make sure that individuals in need of health services and the communities in which they live understand clearly who is responsible for what when it comes to providing health and healthcare services.

Building on Local Initiative and Integration

The reallocation of responsibility and authority from provincial/territorial departments of health to regional health organizations for the management and operation of healthcare services is a powerful and appropriate strategy to enable Medicare to meet the challenges of the 21st century. If we are to continue to meet the healthcare needs of Canadians, the myriad of individual services and programs available to patients must be integrated into a single local/regional health management body to enhance the efficiency and appropriateness of services provided.

Empowering health organizations offers several advantages:

- The "basket" of healthcare services can be adjusted to meet local needs and priorities. The health organizations would have to adhere to national principles and to provincial/territorial system-wide qualitative and performance standards. Also, particularly sophisticated or capital intensive services (e.g., paediatric heart transplants, radiation therapy) should continue to be managed provincially or, in some cases, on an inter-provincial basis;
- Those in charge are known by and directly available and accountable to the people affected;
- Accountability for regional trade-offs is in the hands of those receiving and providing services;
- A sense of "ownership" of healthcare services is re-established among regional consumers and providers (stakeholders);
- Management is more effective;
- Innovation, experimentation and regional variation is encouraged and rewarded; and,
- The results in terms of health outcomes can be compared and successful initiatives applied generally (and unsuccessful ideas avoided).

While partial devolution to such health organizations has been in place in most provinces for many years, its extent from province to province is highly variable. The populations of the regions to which devolution has applied range from very small (as in Prince Edward Island) to quite large (the Capital Health Authority in Alberta, for example). Geographic areas encompassed by these health organizations also vary widely: cities, thinly populated rural areas and remote regions.

Recent decentralization to regional health bodies has not yet, however, produced optimal results in terms of health outcomes, satisfaction of the people served, efficiency of resource utilization, or in terms of recruitment and retention of providers. In part, this is due to the fact that in no province has responsibility and authority for a full spectrum of healthcare services been assumed by these regional bodies. For example, every province has retained central authority over the negotiation and management of payments to physicians, one of the key levers affecting the operation of many other components of the healthcare system. Moreover, in most provinces, cancer and mental health services remain centrally administered, as are support programs for pharmaceuticals. Therefore, the ability of regional health bodies to make a difference has been limited by an absence of control over many key variables.

Reallocation of authority and responsibility for the management/operation of services must be all or nothing. Incomplete devolution of responsibility for common services perpetu-

ates their duplication, sustains the incidence of patients falling through the cracks, and allows continued fragmentation of the continuum of care. In large part, the assessment to date of the results of regionalization has been frustrated by the absence throughout of common standards on such fundamental data as the nature of patient/provider identifiers and encounters, diagnoses, and outcomes. We still lack effective systems to collect, store, measure, analyze, distribute and share health information.

To be effective, the reallocation of responsibility and authority should apply to populations large enough to share the financial risks of providing the full spectrum of health services (apart from highly specialized services that excellence requires be provided centrally or shared by two or more regions). Yet, they should be small enough to engage a sense of responsibility or stakeholding in the people receiving and providing those services. Members of the regional health organization must be truly accessible and accountable to the population served.

Local initiative and commitment built Canadian healthcare institutions, hospitals, and public health service before Medicare. It is essential that local initiative be strenghtened as a vital aspect of the renewal of our healthcare system.

Notes

1 Based on insurance principles of risk-sharing.

2 S.M. Shortell, R.R.Gillies, D.A.Anderson, K.M.Erickson and J.B.Mitchell, *Remaking Health Care in America: Building Organized Delivery Systems*, Jossey-Bass Inc., San Francisco. 1986, p. 7.

GALVANIZING MEDICARE THROUGH ACCOUNTABILITY

To galvanize our publicly funded healthcare system we must ensure that greater accountability permeates it at every level. Each and every decision-maker should know what his/her roles and responsibilities are, and should be fully accountable for his/her decisions. This involves disentangling the blurred lines of responsibility by reallocating roles between local/regional health organizations (hereafter health organizations), the provincial governments and the federal government as described in the previous paper. However, we must also establish clear mechanisms through which decision-makers are made accountable to each other and to the Canadian public.[1]

Provincial Accountability

Canada's Medicare system is unique in the world for including everyone within the same system for the delivery of hospital and physician services and largely precluding the ability to get faster or better care in a supplementary private system. This means all voters, rich or poor, have a common interest in protecting Medicare. Presently, the provincial governments, through their departments of health, micro-manage their healthcare systems. The primary accountability mechanism for health services, therefore, is through the ballot box. But while answering to the electorate at the polls is a good mechanism for ensuring accountability for "big-picture" performance, it does not enhance accountability for the multitude of decisions that have to be made to ensure an equitable and efficient system. Joan Citizen is not likely to shift her vote in a provincial election because her local hospital has not streamlined its information systems or because more resources than is optimal are devoted to "me-too" drugs or because a local gynecologist performs far more caesarians than are medically indicated. We need other mechanisms of accountability for these various decisions.

Responsibility for managing the system on a day-to-day basis should be devolved substantially to health organizations for the following reasons:

1. There is a conflict of interest when the manager of the system is also the supervisor or regulator. It is better to clearly separate these functions so as to create a tension — a system of checks and balances — that serves the public interest.
2. The relatively short length of service of provincial deputies and ministers means that institutional governance expertise cannot be acquired and utilized.
3. We can develop better and more refined accountability mechanisms for devolved local health organizations than is possible for central departments.
4. The enhanced flexibility achieved through smaller management bodies and the greater accountability of these health organizations enable the system to aim for excellence, not just in national or provincial terms, but in every community.

Ensuring Accountability of Health Organizations

The provinces must retain the role of supervision and regulatory oversight of health organizations. However, the day-to-day management responsibilities should be devolved. This being said, international experience has demonstrated that devolution alone will not be sufficient to bring about real change. Measures are needed to ensure that the new decision-makers are accountable. How do we structure the system so that health organizations have both the incentives and the tools to do the best possible job on behalf of the people they serve? We want to make sure that we do not add just another layer of bureaucracy. Health organizations must be made to be true agents for positive change.

Devolution of budgetary responsibility for a broad range of health care is especially important. None of the existing health organizations across Canada have budgets for the broad range of care (i.e. physician care, drugs, hospital services, etc.). They cannot make the best decisions that will match healthcare needs with healthcare services. Health organizations also need the flexibility to determine how best to ensure the delivery of care, whether through public hospitals, for-profit providers, or new reimbursement mechanisms for family doctors.

Performance Agreements

Health organizations should be accountable to the provinces for achieving measurable health goals and healthcare service standards, set by the provinces in negotiation with them. The aim of every health organization should be nothing less than excellence in health care. Accountability measures adopted to monitor their progress should reflect that goal of excellence. We envisage this goal as having short-, medium- and long-term objec-

tives. For example, Alberta may negotiate with one or more health organization to implement a 'telehealth' program over the following year to improve access for those in rural areas and reduce waiting times for particular oncology services, e.g., to 1 month from 2 months. Alberta may also negotiate with its health organizations to put in place over the course of the next five years programs that will decrease Aboriginal infant mortality to the Canadian average. Thus, the regional bodies will be accountable to the province for the performance and the direction it takes, but they retain significant discretion as to how to achieve the goals. Funding for health organizations should be structured to reflect their success at achieving the goals set by government. They should be required to report publicly on their progress at 6-month intervals. These reports should be tabled in the provincial legislatures and be subject to an annual audit.

Performance goals and standards for health organizations should be made public for all to see — in governing legislation and in transparent performance agreements. This will make monitoring easier, by the provincial government and by the people served. Moreover, if goals are clearly and publicly articulated, it is difficult for both governments and local boards to ignore those goals in the spotlight of public scrutiny. The difficult question is what goals should be specified and what weight should be accorded to each.

Much can be learned in this regard from countries like the United Kingdom and New Zealand where, over the course of the last decade, goal-setting and performance agreements have been implemented in the healthcare sector. There is no point in reinventing the wheel; we should harvest what lessons we can from other nations.

Accountability through Choice in a Public System

If health organizations have incentives to make the best decisions possible, we would expect to see them develop a variety of innovative arrangements with healthcare providers. A climate of rewarding initiative and good performance should prevail throughout the integrated regional health community. To this end, funding should follow the patient, wherever possible, as he or she chooses his or her own healthcare provider or institution.

We would hope to see, for example, experimentation in primary care by way of further devolution of budgetary responsibility to groups of family doctors and community nurses, similar to the GP Fundholding initiatives and Primary Care Trusts in the UK. Health organizations could finance groups of family doctors and nurses by way of an annual risk-adjusted payment per patient enrolled with them. With that sum the group would be responsible for financing a range of care (primary, drugs, diagnostic, perhaps elective surgery) for each of their patients. If patients were unhappy with their chosen doctor/nurse group, they could shift to another group, taking with them their risk-adjusted share of public funding. We view this type of initiative as improving accountability through choice within a pub-

licly funded system. If implemented properly, we believe this could be a powerful mechanism for positive change.

Of course, a number of problems must be surmounted to ensure positive effects from allowing choice within a publicly funded system. These include "cream-skimming", the potential lack of competition on the supply side, and gaps in information that prevent people from choosing wisely. These problems are not, however, beyond the bounds of human ingenuity to solve and, again, much can be learned from other jurisdictions. Moreover, the significance of these problems varies considerably depending on the specific healthcare market in question. For example, in addition to experimentation with choice in primary care, we also expect to see experimentation with choice in a sector like home care, where there is a competitive market on the supply side.

Accountability to Citizens and Patients

Health organizations need to be accountable not only to the province but also to the people they serve in their communities. How do we enhance accountability in this regard? There is no magic solution, but there are a number of possibilities that should be considered.

A Patients' Charter — Health organizations should be required to publish and disseminate a statement of patient rights, expectations and responsibilities with regard to the appropriateness, quality and timeliness of care. These Patients' Charters, enacted by the provincial governments following consultations with the health organizations, should include contact names and numbers for patients to call if they feel their Charter entitlements are not being realized. Health organizations should also be required to report annually on how the different hospitals and other providers are performing in terms of meeting these entitlements.[2]

Health Care Ombudsperson — While every healthcare institution and health organization should have in place dispute resolution processes, each province should also consider establishing a healthcare ombudsperson. This person should be responsible for monitoring adherence to the Patients' Charter, hearing complaints regarding all aspects of publicly funded healthcare services — whether with regard to the actions of healthcare providers or health organizations — and should have the authority to order redress to patients as required.

Election — Election of the members of health organizations could enhance their accountability to citizens if the elections are taken seriously and if the electoral process can be structured to prevent vested interest groups from monopolizing the membership. Given the need to ensure that the management of the bodies is highly skilled, a mixed board of appointed and elected members might be appropriate.

Mandatory Consultation — Genuine consultation with the citizens in the community served can improve accountability and help ensure that the priorities and decisions of the

bodies are reflective of local values. The primary emphasis should be on consultation with citizens rather than interest groups. The performance agreements with the province could require reporting on the results of such consultation and the development of strategic plans to meet local concerns.

Accountability of Health Care Providers

Health care providers are centrally important to our healthcare system. Ensuring a high standard of ethics and professionalism on the part of providers is essential. Healthcare providers will be accountable to the health organizations for their performance. However, direct accountability mechanisms between healthcare providers and patients are also vital. Self-regulation by various healthcare professions to enforce codes of ethics and professional standards and the deterrent impact of medical malpractice suits are means to achieve such accountability. We would recommend legislation to protect healthcare providers who "whistle-blow" on substandard performance or decision-making, be it by other providers, hospitals, or health organizations. One leading-edge example from Montreal hospitals is the mandatory disclosure to patients, by the staff and the institutions, of all errors or instances of malpractice that occur.

Notes

1 The specific accountability of the federal government and enforcement of the *Canada Health Act* is the subject of a separate paper. This paper will focus on accountability at the provincial and health organization levels of governance.
2 Please see *A Patients' Charter*, in this series of papers.

A PATIENTS' CHARTER

Several recent trends in our healthcare system point to an emerging need to define precisely and enforce quality-of-service standards for individual patients. The rising level of general education and the exploding universe of readily available information about health matters encourages close questioning of health professionals by patients and their families and even self-diagnosis. Moreover, rigorous methodologies are being adopted for the evaluation of drugs as well as medical and surgical procedures. Such methodologies can now be applied systematically rather than haphazardly, as they have been in the past. Overall, our potential to improve patient care and quality of service has never been greater.

Public disenchantment with the Canadian healthcare system has generated great interest in a formal commitment to the entitlements and responsibilities of all patients in our healthcare system in the form of a Patients' Charter. This idea has been met with enthusiasm as well as a significant measure of scepticism. Broad declarations of principles cannot, by themselves, change the values and behaviour of the entire Canadian health establishment. These types of statements have an uncanny ability to end up being little more than nice words for public consumption rather than practical realities for patients.

A Patients' Charter can and should be more. Properly defined, a Charter can be the embodiment of a genuine societal commitment to high standards of individual care. To be sure, an effective Patients' Charter cannot be created instantly. The necessary requirements are numerous and will be difficult to achieve. But the potential benefits require us to try. The process of creating a Patients' Charter should always be seen as work-in-progress — a system striving toward excellence. It is a new frontier, a better future to be built.

The five principles of Medicare, while important as national statements, cannot serve as the kind of service quality standards we need in a Patients' Charters. The five principles are intended as conditions for federal contributions to provincial program expenditures. In contrast, a Patients' Charters would refer to individuals' entitlements under those programs. More precision is required at the level of the individual patient.

It is also important that Patients' Charters be adopted at the provincial level to allow for an adaptation of the entitlements of patients to the particular circumstances of each province. Only then can they be useful instruments to hold provincial programs accountable.

Conditions For A Successful Charter

An effective Patients' Charter must be built on the following four pillars:

1. Change in health services organizations;
2. A selective focus on the quality of services;
3. A determination to commit incremental resources; and,
4. An effective appeals process.

Several provinces already have introduced some of these elements into their healthcare systems. Some statutory statements of general entitlements can be found in some provinces; others have implemented appeals processes through ombudspersons and the like. These initiatives provide a useful base on which one can build. However, much is left to be done.

Cultural Change In Health Services Organizations

First and foremost, healthcare organizations need to undergo cultural change. Several decades of almost exclusive public funding of core health services and the stress placed on financial retrenchment have pushed the organization of health services into ever closer conformity with a hierarchical-bureaucratic model. Community institutions — such as hospitals that existed well before Medicare was put in place — have lost power. The patient-physician relationship has been weakened. Governments — and the Canadian public — must realize that health care, and especially not-for-profit health care, depends for its success on the initiative and institutions of civil society. This initiative is difficult to sustain in an overly centralized administrative structure.

Delivering high quality personal services is something with which bureaucratic organizations — public or private — have always struggled. The single payer feature of our core healthcare system is a quasi-monopoly in provincial hands. Provinces have a duty, then, to offer patients an effective means to offset the restriction of choice that comes with the public monopoly. Provinces should make room for incentives and sanctions, and empower providers with effective management opportunities and meaningful choices for patients. With this newfound room to manoeuvre, managers could effectively manage; with meaningful patient choice, the system could then respond to those it is designed to served.

The introduction of a Patients' Charter would refocus the delivery of healthcare services on the patient and on the quality of these services in each and every community. Thus,

with a new emphasis on outcomes for patients rather than processes, the current tendency to centralize decision-making and standardize practices across a province would shift to a regionally-managed system flexible enough to be customized to the needs of particular regions and individual patients.

A Selective Focus With Regard To Quality Of Services

Quality of service issues have rightly attracted the attention of the media and fuelled concern among the public. A commitment through a Patients' Charter could help focus attention and resources. Examples of such issues include:

- Medical conditions for which the timeliness of treatment has a material impact on outcomes, such as cancer, spinal cord trauma or strokes, or on quality of life, such as hip replacements or cataract surgery;
- Situations in which patients must have all the information they need to make treatment decisions. This is a particular issue for major procedures in which there are different therapeutic options, for which there is significant variation in the performance or experiences of different individual health professionals, or with which there is a greater-than-usual degree of risk; and,
- Instances in which minimal standards of care cannot be met. Even informed consent is insufficient to justify the provision of certain services in substandard conditions. Some services, for example, require a high volume of procedures to sustain the skill set essential to minimal quality.

A Patients' Charter would have the benefit of focusing the measurement of quality on individual encounters with the system rather than on aggregate numbers. As important as is public health promotion and prevention, a Patients' Charter is directed to individual entitlements, not those of a community at large.

There is much to be said in favour of keeping these provincial Charters to a short list of well-chosen items, at least initially. A Patients' Charter would have to overcome the inherent scepticism of most people regarding public statements of good intentions. If such a Charter is to help in any way, it will require a very substantial commitment of resources to service delivery and implementation processes.

Blanket entitlements covering all personal health services provided to individuals would not be well advised either. Hundreds of millions of contacts between patients and professionals occur every year. Most are of a minor nature (e.g. visits to a physician for a sore throat) and take place in a context that provides a reasonable measure of protection to the patients. Moreover, legal liability is not an empty concept. If one were to attempt to spell out in detail precise entitlements for such an immense field, one would be forced into myriad details — an impossible task.

A Determination To Commit Incremental Resources

A Patients' Charter will force governments to allocate greater resources to our healthcare system. Defining entitlements, by itself, can do little to improve upon the present situation. Additional resources must be made available to enable the system to live up to the entitlements defined in the Charters.

Presently, there is agreement that needed investments would be substantial. For example, to ensure timeliness in service delivery where there are random fluctuations from day to day in the need for services, a degree of excess capacity is required. The greater those variations and the shorter the maximum tolerated waiting time, the greater is the needed excess capacity. Moreover, if genuine informed consent is to become more than an empty gesture, more resources in information systems and education are required. Finally, defining and applying minimum standards means retiring substandard facilities and equipment, replacing some of them, upgrading others, retraining healthcare professionals and, in the meantime and perhaps indefinitely, paying for transferring patients to high quality services when needed.

An Effective And Simple Appeals Channel

Without the extra resources committed to these issues, defining a Patients' Charter will only make the gap between promise and performance more obvious and may well increase litigation. But litigation is expensive and only those with resources are able to pursue a case.

But what are the alternatives to litigation?

Public administration is one of the defining characteristics of the Canadian healthcare system. The natural enforcement mechanism is the political process. Yet, many would doubt that a Patients' Charter could be effectively enforced through such devices as Question Period in federal or provincial legislatures. In Canada, this avenue is further handicapped by citizens' confusion about the roles of the federal government and the provinces in health care.

The most compatible redress mechanism would be simple, relatively inexpensive administrative appeals at the local and provincial levels, perhaps through an ombudsperson responsible for monitoring the system's adherence to the principles of Medicare and the entitlements of patients under the provincial Charters.

In summary, a Patients' Charter would be an important mechanism to improve health care services.

FEDERAL-PROVINCIAL ROLES AND RESPONSIBILITIES: FROM ADVERSARIES TO PARTNERS

While health care is a matter of provincial jurisdiction, the federal government has been a partner in this area for at least 50 years. Mackenzie King's 1945 Reconstruction Conference offered assistance towards a national, universal healthcare program. Federal legislation later codified the foundations of Canadian Medicare: the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1966), replaced in 1984 by the *Canada Health Act* (CHA). Nonetheless, with few exceptions, in our healthcare system, the provinces are primarily responsible for planning and administering health services in Canada and provide the lion's share of the funding for these services.

In the past few decades, this federal-provincial partnership, which had served Canadians rather well, has steadily deteriorated to the point of being dysfunctional. Canadians now witness almost daily childish, sterile bickering between the two levels of government as to who-paid-how-much-for-what-when.

Meanwhile, serious challenges confront Medicare. Citizens' entitlements to services, for which they pay dearly through their taxes, have been eroded.

A renewed partnership is urgently needed. We recognize that tensions and conflicts will always exist in a federation. Nevertheless, mechanisms must be designed to help our governments cooperate to ensure the delivery of high-quality care to all Canadians.

New Rules for a New Partnership

The first rule requested by both levels of government is for accountability for the dollars spent. This is not, it must be said, simply a matter of getting political credit as the source of the funding for an essential public service. There is also an important underlying principle of governance that makes this form of accountability absolutely essential.

Every citizen is entitled to a clear and direct link with all levels of government, not just for services delivered but also for services funded. Thus, it is important that both the provincial and federal governments be able to account fully for how the taxpayers' healthcare dollars are spent.

A second rule would be optimum efficiency and functionality. Which level of government can best serve the common good within the context of the structural changes facing healthcare systems in the 21st century? Understanding that health care remains a provincial jurisdiction and that the natural role for the federal government is the supportive one of facilitator, a realignment of roles and responsibilities as well as of modes of interaction is in order.

The search for optimal efficiency and functionality requires us to address the following questions:

- How can we ensure that Medicare — a coast-to-coast network of 13 health insurance systems — remains truly national?
- Can anything be done to alleviate the burden of healthcare costs and cost control as it now falls directly on the provinces?
- Are there components of the healthcare system in which the federal government could participate more directly?

Renewing Medicare

The first objective on everyone's mind should be excellence in health care. All decisions regarding the roles to be played by the various levels of governance should be made with this goal in mind. Of course, providing high-quality care to all Canadians and building a health system that strives for excellence necessitates a healthier federal-provincial partnership.

All Canadians and all governments repeatedly agree on the core values expressed through the five principles of the *Canada Health Act*:

- Universality — a province's entire population must be entitled to the provincial plan on uniform terms;
- Accessibility — persons must have access to all insured services, while reasonable compensation to physicians and hospitals must be provided;
- Comprehensiveness — the provincial plan must insure the full spectrum of medically necessary hospital and physician services;
- Portability — persons moving to another province or traveling in Canada or abroad must be covered at either host/home province depending on existing agreements; and,
- Public administration — plans must be administered and operated on a not-for-profit basis by a public authority.

While all provincial governments support the CHA, they strongly resent the perceived, and at times real, interference from Ottawa in their way of doing things. Meanwhile, Health Canada is becoming increasingly frustrated in trying to apply the principles of the *Canada Health Act*.

The CHA, during its first years, succeeded in eradicating extra-billing to patients by physicians and user fees by institutions. But during the last decade it has not been able to meet the new, subtle and complex challenges to Medicare. In truth, if quasi-automatic enforcement mechanisms have worked in the past for simple and clear breaches of the Act, only long, complex and highly politically loaded processes are available to address today's complex challenges to Medicare.

Besides conflicting political ideologies, three main drawbacks explain this state of affairs: a decade of unilateral federal budgetary cuts to provincial transfers; ambiguity over the meaning of the five principles of Medicare; and the very nature of the beast — federal intrusion in an area of provincial jurisdiction.

On funding, Ottawa can and should commit itself to stability of funding in health care. To improve accountability to taxpayers, the federal government should introduce a new finance bill that would separate all funds (tax points and cash) transferred to the provinces for healthcare purposes from the funds allocated to other social services — a CHST II of sorts. It would make for a healthier relationship if the tax points "lost" by Ottawa to the benefit of the provinces were once and for all withdrawn from the equation and the debate. Future contributions should be made through cash transfers only.

With regard to defining further the principles of Medicare, Ottawa and the provinces, possibly with citizens' participation, should reinterpret each of the five principles of Medicare. Moreover, a corresponding operational checklist of what is appropriate and what is not under these principles should be created. The lack of definition of these principles has been the root cause of much of the ambiguity regarding how provinces can alter their modes of delivering services while remaining within the parameters of the CHA. Specifically, the federal and provincial governments should consider the meaning of the principle of public administration. What should the relationship be between the public and private sectors in our healthcare system?

The task of reinterpreting these principles is undoubtedly a formidable one — one that will require bold political leadership. But it is a responsibility that must be taken up by our governments. These principles, once clearly defined, should be widely disseminated in plain language.

Many Canadians — citizens, as well as administrators and health professionals — would like to see other principles, such as quality and accountability, added to the list to create a truly modern healthcare system. In the longer term, the CHA should be monitored by

a national health council, jointly appointed by Ottawa and the provinces and operating at arm's length from the governments. The council could, for example, be mandated to present detailed report cards on the performance of the system in terms of the health status of Canadians, adherence to the principles of Medicare and the provincial Patients' Charters. The council's role could be undertaken by existing bodies such as the Canadian Institute for Health Information and the Canadian Institutes of Health Research, for example.

Recognizing that the financial and operational responsibilities related to the CHA are overwhelmingly provincial, the role of the federal government in this component of health care must be one of facilitator and honest broker between the provinces. Through stable funding to which it would commit itself, the federal government would enable the provinces to better plan for the future needs of their healthcare systems. Armed with the reinterpretation of the five principles of Medicare (to which all governments will have agreed) and aided by the arm's length national health council, the federal government would also be in a much stronger position to monitor adherence to the CHA. Enforcement through penalty is, of course, always an option, but the federal government should commit to using this instrument only in extreme cases. Otherwise, negotiation and mediation should be the preferred means of enforcing the CHA.

This task is fundamentally important to ensuring that Canadians continue to enjoy an effective, fair and universal system for health services. Harmonizing 13 ever-evolving provincial healthcare programs will require constant attention. Certainly, with its share of total spending having been dramatically reduced in the last few decades, the federal government will have to be creative in devising mechanisms through which it can retain its national role. But this is an important task, and one that is essential.

More Comprehensive Services

The first areas in which enhanced services should be considered are home care and pharmacare. With day surgeries and earlier hospital discharges, it has become evident that we should seriously consider making a continuum of homecare services and programs available to all Canadians on an equitable and universal basis. This entitlement should be an intrinsic part of their healthcare insurance. Although an array of homecare services has developed across the land — be they for-profit or not-for-profit services provided by the private or public sector — the regional disparities in terms of access and entitlement to homecare services are simply not acceptable.

Home care will require new funding from governments, a formal policy framework and the associated accountability mechanisms.

There is more than one way of protecting Canadians from the ever-increasing burden of drug costs, the Quebec model being one worthy of study. As a matter of principle, a

national pharmacare program should be universal in the coverage achieved, equitable, and efficient. An alternative would be greater standardization and harmonization of provincial drug plans. National standards negotiated among governments would govern these plans. Together, governments need to plan and finance broader, fairer coverage for drugs.

It must be made very clear, however, that any funding for additional programs such as the ones outlined above cannot come at the expense of present funding levels of core services or the natural increase of those levels of funding to account for inflation and demographic changes.

Long-term care, another much needed spectrum of institutional and individual services, is a separate issue. With the aging of the population, the issue becomes urgent and involves major expenditures that governments may or may not be able to handle on their own. Canadians would benefit from discussing different ways of tackling the problem. One that comes to mind is the model adopted by Germany in which long-term care is funded by workplace premiums.

Our healthcare system will not achieve excellence as an integrated system without the pervasive use of information technologies on the one hand — from basic wiring to standardization and conversion of files, software development and training — and appropriate state-of-the-art medical technologies on the other. We consequently recommend consideration of the creation of a joint federal-provincial Health Technology Resources Fund, as a source of capital investments, to be re-assessed after its first 10 years of operation.

A NATIONAL APPROACH TO PHARMACARE

Pharmaceuticals and Health Care

Pharmaceuticals are integral to modern health care. Their innovation and use in the 20th century transformed the health of populations around the world. Drug therapy is a growing part of care at every stage of health care: primary, emergency, acute, outpatient, home and long-term — not to mention self-care by individual consumers. Drug technology, though expensive and time-consuming to produce, continues to offer advances in every facet of medicine. With genomic research in its infancy, pharma-technology will continue to transform health care in the 21st century.

Multinational firms, some with a substantial presence in Canada, dominate the research, production, marketing and distribution of drugs. Unlike other parts of the health-care system, the distribution and use of drugs are strongly affected by private sector competition among pharmaceutical firms and their marketing strategies. Increasing emphasis is being placed on consumer choice and access. The marketing of new drugs is increasingly focused on consumers as well as physicians.

The average cost of individual drug therapies, and the total cost of prescribed and non-prescribed drug consumption has been increasing dramatically in Canada, as in other developed countries. In fact, drug care costs have risen faster than any other facet of health care. In Canada, these costs now exceed the amounts spent on physician services.

The increased use of drugs has been an important element of change elsewhere in the system. It has made possible many outpatient and day surgery procedures, reducing dramatically the requirement for hospital beds, and it has enabled psychiatric patients to live outside institutions.

While drug therapy has become an essential part of the system, it has not been treated as a fully "medically necessary" service under Canada's Medicare system. Equity and access have been public policy concerns for decades, and there is an increasing sense of

unfairness in the system as drug therapy increases in cost and frequency but remains outside publicly insured core services.

Another key issue is the need for better management of drug use in order to deal with over-prescription and patient non-compliance. And cost-containment by all drug consumers (institutions, individuals and insurance plans) is of major concern. All these issues intersect with concern about the patchwork of public and private insurance programs that exist to fund prescription drugs. Presently in Canada, the cost of pharmaceuticals is borne by individuals, employers and provincial governments in roughly equal measure.

A final, important opportunity is that reform of pharmacare could make an important contribution to the disentangling of healthcare financing in Canada.

Insurance Patchwork and Other Issues

Canada and the United States stick out among OECD countries in not having comprehensive national drug insurance programs. In several countries, the coverage of their national programs is 100 percent, or nearly so, of the total population (e.g. Britain, France, Italy, Australia, New Zealand, Sweden, Denmark, Norway, Netherlands). Nowhere do the national plans cover the full costs of drugs to the patient. Some come close, at 90 percent in the Netherlands and UK, but the norm is a more evenly balanced co-payment such as France at 54 percent and Australia at 50 percent. In Canada as a whole, about 25 percent of the population are covered by public plans, which pay about 48 percent of the total drug bill.

Canadians are covered by a patchwork of public and private plans. The federal government covers full costs for status Indians, military personnel, penitentiary inmates and veterans. Provinces and territories cover costs for social assistance recipients, and all cover seniors to some degree, but with as much as a ten-fold difference among provinces in the cost to patients of co-payment or user fee requirements. Provincial plans tend to cover more of the costs for specific drugs for certain diseases and conditions (e.g. AIDS, cancer, cystic fibrosis) but there are significant gaps across provinces.

Many employed Canadians are partially covered not by public plans but by private ones, financed mostly through payroll taxes (i.e. employer and employee contributions). The result is that Canadians who do not work full-time, or who are self-employed, tend to have no coverage, and those with coverage face significant charges. In total, there is a weak link between pharmacare need and insurance coverage.

Across Canada, the out-of-pocket costs for patients have been increasing, a result of reducing in-hospital care, where drugs are free to patients, and changing policies to contain costs. This cost shifting may be effective for health institutions but has the effect on consumers of decreasing equity and access. Drugs are increasingly important to healthcare therapies but, increasingly, a financial burden to individual Canadians.

The Need for a Coordinated Approach

The multiplicity of drug plans and regulatory regimes across Canada hinders a comprehensive approach to overall cost containment. It may also reduce effective strategies for better pharmaceutical use. Really effective cost containment will require sufficient buying and regulatory power to match the clout of the large pharmaceutical firms.

Other strategies for cost containment include regulatory price cuts and aggressive bulk-purchasing: both are likely to be more effective if pursued by larger, single purchasers. A recent innovation adopted in some provinces is a reference-based pricing system. In this approach, all effective drug therapies in a reference class (e.g. arthritis control) are compared — regardless of similarity in pharmaceutical terms — and only the most cost-effective is approved for payment. Some have also advocated a national drug formulary, i.e. a single, national regulatory process for determining which drugs will or will not be covered by insurance plans.

Demand management for drugs is another key way to contain costs and provide more effective use. The link to primary care reform is compelling. Drug plans integrated with primary care can ensure access while simultaneously promoting cost control and more appropriate use. This approach is now in place in the UK and is being tried in the Netherlands.

A National Approach to Pharmacare

Over the long-term, Canada must address pharmacare. Drug technology is a major driver of system change, including the scope of institutional care, the role of the consumer/patient, and the demand for healthcare services. Three key and inter-related issues have emerged that governments must deal with:

- Controlling drug costs and providing incentives for more appropriate drug use;
- Ensuring healthcare equity and access are not being eroded by drug cost-shifting to individuals; and,
- Harmonizing and strengthening the regulation of public interest.

In our view, the status quo can neither effectively contain drug costs nor prevent equity/access gaps from widening.

Significant organizational issues will need to be overcome to implement a national approach to pharmacare. These issues include: addressing the compulsory retention of employer plans; a mechanism for a regulatory updated formularies based on best evidence; cost efficiency; and the appropriate cost burden on individuals. Quebec's experience provides important lessons for pursuing a national approach to a universal drug plan.

Attention should also be paid to how to ensure drug plans contribute to primary care reform objectives, in particular, to ensure physicians are more sensitive to the costs and benefits of the drugs available for use.

In the initial phases of hospital and physician insurance, employees and individuals retained some financial responsibilities that pre-dated a larger public role. Our goal is not to shift the financial burden from employers to taxpayers. Our goal is to make the burden on individuals much more equitable. The overall cost of pharmaceuticals in Canada will continue to rise, but the burden will be more equitably borne.

Moving to a solely federal drug plan may prove too radical for the current state of federal-provincial relations. A second option would be the development of national standards to be accepted by each provincial drug plan. Chief among these standards would be universality. All Canadians would be covered.

The current level of cost-sharing between patients and governments would be made the same across Canada. Considerations would be given to a premium-based approach supplemented by cost sharing. Employers would continue to contribute to pharmaceutical expenses.

Whatever the details of the chosen program, the reality is that new federal financial support is essential to ensuring all Canadians equitable access to pharmaceuticals.

CHARTING A NEW COURSE TOWARD EXCELLENCE IN HEALTH CARE

As governments engage in the debate about how best to reform our healthcare system, Canadians should urge them to strive to achieve nothing less than the highest international standards of excellence in health care. At present, minimum thresholds of adequacy are too often seen as acceptable outcomes for our system. Our system has great potential, but it is severely underperforming.

Thoughtful Canadians reject the notion that we should celebrate the limited outcomes which have come to characterize our system's performance. As a country, we can and should do better. Most Canadians continue to express faith that excellence in health care is achievable in a publicly funded system. Health is of such vital concern to everyone that excellence in health care must be more than our desire — it must be our goal.

The five principles of the *Canada Health Act* express the values of Canadians and their support for a publicly-funded system. But none of these principles refers explicitly to quality. Indeed, many inferior health systems around the world would be entirely consistent with the five principles of the *Canada Health Act*. Canadians familiar with these healthcare systems would reject them, and rightly so, because standards of excellence and quality are not assured. The issues of quality and excellence — which encompass the notions of appropriateness and timeliness — are a matter of great and urgent importance to all Canadians. So should it be for governments as they seek to maintain and build public confidence in the system.

Healthcare Excellence as a Canadian Brand

As governments seek to improve our healthcare system, our principal goal must be to meet the highest international standard of excellence. Our publicly funded healthcare system is our most cherished social program and has been elevated to the status of a defining Canadian

value. That value is best preserved by an unrelenting commitment to international standards of excellence.

As Canada's flagship social program, our healthcare system has the potential to establish Canada's brand as the one to emulate for quality of life and commitment to excellence. This would help ensure that Canada retains its status at the top of the United Nations World Development Index and improve our current seventh place position in the World Health Organization's measurement of overall health system attainment.

A National Strategy

Our federal and provincial governments must coordinate efforts to achieve excellence. The federal government, for its part, would act as a facilitator, catalyst, consensus builder and coordinator in this effort. In partnership with the provinces, two specific tasks should be led by Ottawa. The first task would consist of providing the infrastructure necessary for determining and applying international benchmarks. The second would see Ottawa fund experiments to explore and evaluate different ways to achieve appropriateness and excellence of health care. These experiments would then serve as an example for wider application throughout the system by the provinces.

We foresee a joint strategy that would push all governments to:

- Provide a bold declaration of the collective will to move Canada's healthcare system to the highest international standards of excellence, and to move beyond the intermittent and episodic efforts to fix and fund one or other problems in the system.
- Elaborate a more constructive long-term plan. Key elements to be addressed include:
  - Availability and training of health human resources;
  - Required upgrades in facilities and equipment to meet international benchmarks;
  - Organizational structures, management, measures, outcomes and accountabilities; and,
  - Appropriate levels of funding.
- Measure and report on the performance of Canada's healthcare system, evaluated against international standards, trends and developments. These would be dynamic, not static measures. For example, current research investment by the National Institute of Health in the United States is $18 billion per year, versus Canadian research investment of $550 million per year.
- Encourage differentiation and experimentation among the different provincial healthcare systems and regional health organizations: not every province or health

organization necessarily should or could be the best in everything at the same time. As a matter of principle, best practices would be shared and exported.

- Define outcomes and measurements, including consumer satisfaction. A mechanism for the evaluation of excellence, such as a peer review process, must be developed. This mechanism could be based within an existing healthcare body such as the Canadian Institute for Health Information or the Canadian Institutes of Health Research, or a joint venture of the two.
- Develop a Canadian healthcare management and health industries sector. If Canada can achieve global standards of excellence, it follows that other countries and purchasers will want access to that knowledge. A sweeping and comprehensive strategy to put Canada's healthcare systems at the forefront of the global knowledge-based economy has the potential to provide substantial dividends that can be reinvested here at home to improve the health of Canadians.

Healthcare Management and Industries Sector

Health care is one of the largest sectors of employment in the Canadian economy. The publicly funded system contributes greatly to the health of the population. A healthy workforce is essential for a healthy economy but, beyond that, Canada's publicly financed healthcare system provides a competitive advantage to Canadian industries by greatly reducing the amount employers pay for employee health benefit packages.

Canadians make a substantial ongoing investment — $80 billion per year — in our healthcare system. Strategies to develop the export of healthcare services and management and to expand our production of goods and services that stem from the health sector are the best way to get a return on our investment. We think a target of 20 percent, or $16 billion per year generated by this industry sector, is a reasonable goal.

Industry sub-sectors that show promise include:

- Information technology (digital and satellite applications);
- Healthcare delivery services;
- Healthcare management;
- Knowledge management systems: including data collection, transmission and security, and software development;
- Biotechnology: genomics (artificial organs, drug development, etc.);
- Imaging systems; and,
- Nanotechnology.

Canada should not be afraid to aim for excellence. We have the necessary expertise. All we need now is the leadership and collective commitment to make excellence a reality.

LESSONS FOR CANADA FROM OTHER NATIONS

Many nations look to Canada for leadership in health services. Perhaps it is time Canada looked to other nations for insight and lessons.

Canada shares with most other OECD nations an experience of public sector retrenchment in the healthcare sector in the 1990s, and a current sense of public concern about levels of public funding for health care. During the 1990-97 period, the average rate of increase in real per capita public expenditures in 24 OECD nations slowed to 2.6 percent, after the decade of the 1980s in which such expenditures had increased on average by about 4 percent a year. This braking of public expenditures was reflected in a decline in the public share of total health expenditure: the OECD mean in this regard declined from 75.7 percent to 74.7 percent between 1990 and 1997. The impact of this retrenchment is reflected in public opinion. In a recent seventeen-nation public opinion survey, which included 11 OECD nations, majorities ranging from 68 percent in Germany to 91 percent in Britain supported increased public spending on health care. The level of support for increased spending was inversely correlated with changes in the public share over the previous decade: that is, support for increased public spending was generally higher in those countries in which the public share of total health expenditures had declined most severely.

In Canada, these trends have been particularly sharp. Canada was one of only four of 24 OECD nations in which real public health care expenditure actually declined over the 1990-1997 period — the average annual change in real per capita public expenditure in that period was (- 0.4) percent. The public share of total health expenditure in Canada declined from 74.6 percent in 1990 to 69.8 percent in 1997. And the effect on public opinion has been dramatic. Canadian respondents showed the largest drop among five nations surveyed between 1988 and 1998 in the proportion believing that the healthcare system works well and that only "minor changes" are required to make it work better — from 56 percent in 1988 to 20 percent in 1998.

The effect of the contraction of the public sector in Canada was exacerbated by the design of the Canadian system. Uniquely among OECD nations, the boundary between public and private finance for health care in Canada is drawn along sectoral lines. Medical and hospital services are covered under a universal single-payer system of first-dollar coverage, while other goods and services fall into a realm in which methods of financing are mixed and varied, and in which private finance plays a large role. This sectoral division between public and private finance contrasts with other systems in which private finance takes the form of co-payments for publicly-insured services, or of a system parallel to the public system, or of coverage for population groups ineligible for public coverage. Because medical and hospital services are exclusively publicly insured in Canada, it was those sectors that bore the brunt of public restraint. And because those services have traditionally been perceived to be at the core of the system, the effect of fiscal constraint on public confidence in the system was amplified.

If Canada achieved a greater degree of fiscal constraint than did most other OECD nations in the 1990s, it did so without adopting the types of healthcare reform that other nations did. Beyond regionalizing hospital governance structures (in all provinces but Ontario), Canada made very few changes to the structures of healthcare delivery or finance. Other nations, meanwhile, made a variety of changes that fell into the following categories.

COMPETITION

A number of countries, notably Britain and New Zealand, tried to introduce elements of competition into their publicly owned and managed hospital systems by breaking up established hierarchies into "purchaser" and "provider" components and requiring purchasers to contract for services with providers who were expected to compete for purchaser contracts. These "internal markets" were still publicly financed. These reforms also allowed private providers to compete for public contracts.

In other nations, competition among insurers within an overarching framework of universal coverage was encouraged. The most prominent example was undoubtedly the failed "managed competition" proposals of the Clinton administration in the United States. But social insurance systems in Germany and the Netherlands also moved toward "managed competition" as regulatory frameworks were changed to allow social insurance funds to compete with each other (and, in the case of the Netherlands, with private insurers as well).

Verdict: The actual impact of these competition-based reforms has been less than might have been expected from their initial design. "Internal markets" in Britain and New Zealand have resulted in more explicit negotiations between public purchasers and health care providers, but competition between providers has been limited as established networks have persisted in the process of implementation. Too little attention has been paid to the accountability of the purchasing bodies. As for managed competition among insurers, that

too has been limited by the difficulties of developing feasible risk-adjustment mechanisms — although important strides in that direction are being made, especially in Germany.

Implications for Canada: The original structures into which these competition-based reforms were introduced were quite different from those that prevail in Canada. In Britain and New Zealand, the starting point was a system in which hospitals were owned and managed by the state, and the move to establish hospitals as entities incorporated separately from funding authorities was arguably a move toward the model already prevailing in Canada. As for competition among insurers in Germany and the Netherlands, those reforms built on the model of multiple social insurance funds, financed by compulsory employer and employee contributions, that has prevailed in a number of European countries since the late nineteenth century. That contrasts with single-payer systems, financed by general taxation, that exist in Canada and other nations. Experience with these reforms can thus not be directly translated into the Canadian context. Nonetheless, there is something to be learned from experience with competition-based reform. "Purchaser-provider" negotiations have demonstrated the potential merits of more explicit agreements in encouraging purchasers to be more sophisticated and providers to be more accountable. Value-for-money, quality and access can all be enhanced through more explicit agreements. And the advances in risk-adjustment formulae, developed to facilitate competition among insurers, can be adapted to other forms of population-based funding.

CHANGING PROVIDER INCENTIVES

Competition-based reforms were intended to provide both purchasers and providers with greater efficiency incentives. But they were not the only types of reform directed at changing provider incentives. Another had to do with extending the "agency" role of physicians by providing physicians with fixed budgets from which they were to purchase goods and services as agents for their patients. British GPs who opted to become "Fundholders" were given budgets from which to purchase a range of hospital and community services for their patients, with the savings to be re-invested in their practices. In Germany, regional associations of physicians have been given budgets for prescription drugs.

Verdict: Policies aimed at changing provider incentives by internalizing costs to groups of physicians have been among the most successful of the reforms of the 1990s. The British Fundholding experiment attracted a majority of GPs on a voluntary basis and has now been extended on a universal basis in the form of Primary Care Commissioning Groups. Germany's regional prescription drug budgets have constrained the rate of increase in the drug component of healthcare expenditures, although other elements of the German system have made for relatively high drug prices.

Implications for Canada: The success of the British Fundholding experiment has important implications for primary care reform in Canada. The attractiveness, for both patients and

physicians, of empowering general practitioners to make a broad range of purchasing decisions on behalf of their patients, was demonstrated by the way in which this initially voluntary option gained acceptance and was then universalized and made compulsory. Although the process of universalization will bear careful watching, the British experience suggests that Canada could considerably accelerate experimentation with primary care reform pilot projects.

ACCOUNTABILITY

A number of nations have instituted policies aimed at increasing the accountability of health care purchasers and/or providers, through changes in governance structures or through the provision of information, or both. In Britain, for example, the chief executives of provider trusts are now held explicitly accountable for the quality of care within a framework of "clinical governance" established after 1997. A variety of quantitative performance measures related to service provision are published for each hospital trust. At the national level, the National Institute of Clinical Excellence (NICE) has been established to undertake technology assessment and the development of clinical guidelines.

Verdict: Various approaches to enhanced accountability are still very much under development and have yet to be fully implemented, tested and evaluated. Performance measures have so far been heavily weighted toward "process" measures such as waiting times rather than "outcome" measures. The implementation of performance measurement schemes continues to be bedeviled by difficulties of controlling for differences in case mix in a way that is transparent and understandable to a broad public. Nonetheless, the drive for information-based accountability mechanisms is likely to continue and indeed to accelerate in most nations.

Implications for Canada: Canada has the potential to be at the forefront of the cross-national drive to improve information-based accountability mechanisms if key gaps that exist at present are addressed. Important elements of an information-based accountability system are already in place in Canada in the form of the extensive databases generated for administrative purposes by provincial health insurance plans and hospital management as well as a growing analytic capacity through university-based centres of excellence in health services research and national bodies such as the Canadian Institute for Health Information and the Canadian Health Services Research Foundation. These bodies are still in their formative stages, however, and need further development. Significant data gaps need to be overcome, particularly with regard to primary and community care. Standardization of data is also an important issue. And perhaps most important, more work needs to be done in developing a coherent framework to guide the collection and assessment of data, on the model of the National Accounts. Only then will we be able to transform the information we have gathered into knowledge we can use.

INTEGRATION

Integrating long-term care and sub-acute care with the acute care system in a way that ensures patients receive the level of care most appropriate to their needs is a thorny problem with which all nations are wrestling. The particular budgetary and organizational barriers to integration vary across nations as a result of the different ways in which structures of health-care delivery and financing have evolved; in no nation are the interfaces between levels and types of care barrier-free. As a recent symposium in the journal *Health Affairs* noted, all nations are struggling to find a balance between family, marketplace and state in achieving this integration. Two reforms worthy of particular note are those of Germany and Japan, which have adopted universal programs of long-term care based on a social insurance model of financing, funded through payroll levies.

Verdict: The German and, especially, the Japanese reforms are too recent to be evaluated, but they bear watching. In different ways both try to balance coordination and universality with a substantial degree of consumer choice — Germany, for example, allows for a "cash option" that patients can draw in order to reimburse family members for the provision of care. Costs of the German system appear to have been contained. In Japan, fears of cost escalation have been expressed based on past experience.

Implications for Canada: The German experience, which has influenced the Japanese approach, also raises important questions for Canada. Should Canada consider a form of universal coverage for long-term care, financed separately from Medicare on the one hand and from public pensions on the other?

In conclusion, a look at other nations can put the current sense of healthcare crisis in Canada in perspective. The fiscal contraction of the 1990s was particularly sharp in Canada, and particularly alarming to Canadians, but it does not place them on another planet than other industrialized nations. And as Canadian governments turn to considerations of re-investment, they can also take guidance from experience elsewhere. No reform can be transplanted from one nation to another and simply be expected to take root and flourish in a different context. Nonetheless, experiences in other nations suggest that reform efforts could be focused fruitfully, for example, on changing the incentives faced by providers, particularly at the level of physician groups, and on developing a new fiscal framework to facilitate the integration of long-term care with acute care.

The members of the IRPP Task Force on Health Policy are:

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Minister of National Health and Welfare from 1976 to 1984, ***Monique Bégin*** was the Dean of the Faculty of Health Sciences at the University of Ottawa from 1990 to 1997, before being named Professor Emeritus. A sociologist, Monique Bégin is now a Visiting Professor at the Health Administration Programme at the University of Ottawa.

Colleen Flood, Assistant Professor in the University of Toronto's Faculty of Law, is associated with its School of Health Services Administration. She specializes in the legal, economic and public policy dimension of healthcare systems. Her research interests include accountability in health care and governance issues surrounding regional health organizations. Most recently, Dr. Flood published *International Health Care Reform: A Legal, Economic and Political Analysis* (Routledge, 2000).

From 1971 to 1981, ***Claude Forget*** served the province of Quebec in various policy-making roles, first as Assistant Deputy Minister of Health and, later, as Minister of Health and Member of the National Assembly (MNA). Since 1982, he has been acting in the private sector as a consultant corporate executive businessman. In 1998, he co-authored, with his wife Monique Jérôme-Forget, *Who is the Master?* a book proposing fundamental overhaul of the financing and organization of the Canadian health system.

Henry Friesen is Chairman of the Board of Directors of Genome Canada and, until July 2000, was President of the Medical Research Council of Canada. During his term as President, Dr. Friesen was instrumental in changing the culture of this organization and oversaw its transformation into the Canadian Institutes of Health Research. Between 1973 and 1992, Dr. Friesen was a Professor and Head of the Department of Physiology at the University of Manitoba.

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Now retired, ***Duncan Sinclair*** chaired Ontario's Health Services Restructuring Commission. A long-time faculty member at Queen's University, Dr. Sinclair served in a number of senior administrative capacities including Vice-Principal for Health Sciences and Dean of Medicine. Dr. Sinclair has also served on a number of boards, commissions and committees including the National Forum on Health and the Premier's Council on Health, Well-Being and Social Justice.

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